

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Underground Coal Mine

Fatal Powered Haulage Accident
January 26, 2017

#2
R & C Coal, LLC
Stone Coal, Pike County, Kentucky
ID No. 15-16855

Accident Investigator

Anthony Benton
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
District 5
P.O. Box 560, Wise County Plaza
Norton, Virginia 24273
Scott M. Beverly, Acting District Manager

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OVERVIEW

On Thursday, January 26, 2017, Ray Hatfield Jr., a 42-year-old miner with over 23 years of mining experience was fatally injured when he became entangled in the shaft of the moving conveyor belt drive tandem roller for the section belt. The victim was positioned between a guard and the conveyor belt drive when he came in contact with the shaft of the belt drive tandem roller. The guards around this belt drive were inadequate because they were not securely fastened and could be easily removed. The accident occurred because the mine operator did not have effective programs, policies, or procedures in place to ensure that power was de-energized and machinery was blocked against motion prior to performing work in close proximity to conveyor belt drives.



This photo shows the space that existed between the guard and the roller at the time of the accident. It also shows the stud bolts extending from the inby tandem roller shaft. These bolts are similar to the bolts that extended from the outby roller shaft where the accident occurred.

GENERAL INFORMATION

The #2 mine is an underground mine operated by R & C Coal, LLC. It is located off Stone Coal Road on Cochran Lane near Pikeville, Kentucky. There are nine employees at this mine. The mine operates one production shift per day, five days a week, and produces approximately 150 tons of coal per shift. Coal is mined from the Elkhorn #3 seam by one conventional mining section and is transported to the surface by three belt conveyors. The mine is ventilated by one exhausting mine fan that produces approximately 60,000 cubic feet of air per minute.

The principal officers for the mine at the time of the accident were:

Mark Daugherty.....Owner/ Superintendent
Raymond Hunter.....Section Foreman

At the time of the accident, a regular (E01) safety and health inspection was in progress. The previous E01 inspection was completed on December 27, 2016. The Non-Fatal Days Lost (NFDL) injury incident rate for the mine operator in 2016 was 0.0 compared to the national NFDL rate of 3.39 for mines of this type.

DESCRIPTION OF ACCIDENT

On Thursday, January 26, 2017, Ray Hatfield Jr., Beltman, did not arrive for work at the normal start time of 5:00 a.m. In a telephone call, Mark Daugherty, Superintendent, asked Hatfield if he wanted to go to the section feeder when he arrived or if he would rather work on the belts. For the past few weeks, Hatfield had been assigned to work at the feeder to break rocks to prevent them from damaging the belt. Hatfield told Daugherty that he would prefer to work on the belts during this shift. As a result, Tracy Hall, Beltman, was assigned to work at the feeder.

Hatfield arrived at work at approximately 7:00 a.m. to begin his shift. Hatfield entered the mine and proceeded to the No. 2 belt drive where routine clean up and maintenance work would have been part of his duties. He then proceeded to the No. 3 belt drive. Tracking information indicated that Hatfield arrived at the No. 3 belt drive at 8:15 a.m.

Hall spoke with Hatfield on the mine phone at approximately 11:00 a.m. after the No. 3 belt stopped moving. Hatfield told Hall that he stopped the belt and would start it in a minute. Hall stated that the belt came back on in 30 to 45 seconds and ran continuously for the rest of the shift.

Evidence at the scene indicated that at some point during the shift, a piece of plastic ventilation curtain had been moved and a 25 inch by 48 inch section of guard had been removed to gain access to the No. 3 belt drive. Hatfield positioned himself in an area

where the clearance between the outby tandem roller shaft and the guard was 24 inches to 28 inches wide. His clothing became entangled in the rotating stud bolts that were extending from the outby tandem roller shaft. Hatfield was pulled into the shaft of the roller, resulting in fatal injuries.

At approximately 2:15 p.m., at the end of the shift, miners returned to the surface. Daugherty realized that Hatfield was not outside. He located Hatfield's last position with the tracking system and made unsuccessful attempts to contact him by mine phone. Daugherty then traveled back into the mine and to the No. 3 belt drive where he discovered Hatfield with fatal injuries. Daugherty then returned to the surface and reported the accident to MSHA and the Kentucky Division of Mine Safety.

Anthony Benton, MSHA Coal Mine Safety and Health Inspector, and Danny Deel, MSHA Supervisory Mine Safety and Health Inspector, entered the mine with Randal Smith, Branch Manager for the Kentucky Division of Mine Safety and Russell Roberts, Pike County Coroner. At 5:10 p.m. they arrived at the No. 3 belt drive. At 5:15 p.m., Roberts pronounced Hatfield deceased. Clayton E. Sparks, District Manager; Lloyd Robinette, Assistant District Manager for Enforcement; Rodney McIntosh, Mine Safety and Health Inspector; Robert Matthews, Kentucky Mine Safety Specialist I; and John Ferrari, Kentucky Mine Safety Specialist II also assisted with the investigation. At 6:40 p.m., Hatfield was removed from the mine and transported off mine property by the coroner.

INVESTIGATION OF ACCIDENT

At 2:35 p.m. on January 26, 2017, the MSHA Emergency Call Center was notified of the accident. The call center notified Robinette, who then called Deel. Deel notified the mine operator and told him to preserve the accident scene. At approximately 3:30 p.m., MSHA personnel arrived at the mine and issued a 103(k) order to ensure the safety and health of the persons at the mine until the investigation could be completed. Benton was assigned to lead the investigation.

The accident investigation was conducted by MSHA personnel in conjunction with the Kentucky Division of Mine Safety. The persons participating in the accident investigation are listed in Appendix A. Investigators obtained information, measurements, and photographs during a physical examination of the accident scene.

On January 27, 2017, and February 9, 2017, formal interviews were conducted at the MSHA Field Office in Pikeville, Kentucky. On February 28, 2017, Joey Taylor, Outside Electrician, was interviewed at the mine site. A list of persons interviewed is located in Appendix A.

DISCUSSION

Guarding

The No. 3 belt drive was guarded with a chain link fence that surrounded the drive. The fencing was secured to metal posts with clamps, and the posts were wedged against the mine roof by screw jacks. This type of area guard is not suitable because it guards an area where frequent access is required to perform routine clean-up and maintenance work around the belt drive. In addition, there were no signs to warn persons entering the area to de-energize the machinery. This guarding was installed in a manner that allowed a 24-inch to 28-inch area to exist between the guard and the outby and inby tandem roller shafts. There was no guarding provided for the shafts.

A 25-inch by 48-inch piece of expanded metal covered an opening in the chain link fence near the boom of the belt drive but had been removed from the fence and was lying on the ground at the time of the investigation. During his interview, Hall referred to this section of guard as a “door.” This type of guard was insufficient to ensure safety because it was not substantially constructed and firmly bolted. While the guard had the appearance of being bolted to the chain link fence, upon further investigation, it was discovered that it was not bolted onto the fence, but rather, hung on the fence and could be removed easily. A photo depicting the manner in which this guard was installed has been included in Appendix B. Hall stated that he commonly de-energized the belt drive and entered the “door” to shovel in the area.

Hatfield entered the fenced area through the opening normally covered by the “door” and positioned himself in the area between the tandem roller shaft and the fence. It appears that Hatfield was shoveling in this area because investigators found coal and rock material in the Y-handle shovel he had been using. As previously stated, while Hatfield was in this area, his clothing became entangled in the rotating bolts that were extending from the outby tandem roller shaft, and then in the shaft of the belt drive tandem roller, resulting in fatal injuries.

The guards for the three belt drives at this mine were redesigned following the accident. The area guards and “door” no longer exist and the new guards are securely fastened and installed in a manner that allows the belt drives to be shoveled without having to remove the guards.

Belt Drive

The No. 3 belt drive is a 480 VAC, 36-inch drive that utilizes one 100 horsepower motor to drive the tandem rollers. This belt operates at a speed of approximately 400 feet per minute. The tandem rollers rotate at a speed of approximately 90 revolutions per minute. At the time of the accident, the belt conveyor was approximately 1,080 feet long and was operating with only the inby tandem roller being pulled. While the outby tandem roller could be linked mechanically to the inby roller by bolting wheels onto the

shafts, there were no wheels on the shaft. Both shafts with hub adapters were protruding from the belt drive toward the fencing. There is a ¾ inch diameter stud bolt welded to the center of each shaft that extends outward 3 inches. Each of the hub adapters has ½ inch diameter studs with nuts that extend 1¼ inches from the end of the shafts. There are 3 of these studs on the outby shaft and 4 on the inby shaft (see Appendix C).

Tracking and Communications System

This mine utilizes a Strata Comm Trac communication and tracking system. The system works by using the received signal strength indicator to calculate a probable location of where a miner could be by correlating the signal strength to an electronic node (node). The node where Hatfield was located was the “Belt 12” node which is located at the No. 3 belt drive. The adjacent nodes to the Belt 12 node are the Belt 10 node which is 121 feet outby the No. 3 belt drive along the No. 2 belt, and the Belt 15 node which is 184 feet inby along the No. 3 belt. The number in each belt node name is the crosscut where the node is located.

The tracking information indicated that Hatfield arrived at the No. 3 belt drive at 8:15 a.m. The tracking system data did not indicate any change in location after Hatfield arrived at the No. 3 belt drive because the tracking device was discovered in Hatfield’s dinner bucket at that location.

Managerial Oversight and Examinations

Raymond Hunter, Section Foreman, and Daugherty routinely perform preshift and onshift examinations and also perform several other duties at this mine. However, Daugherty is also the shot firer on the section and performs routine clean-up and rock dusting. Daugherty stated that he performs whatever duties are necessary to mine coal. Hunter also operates the roof bolting machine and stated that he regularly “floats” out other equipment operators. In addition, Hunter also maintains ventilation curtains and “fills in” for someone if they are off. These extra duties interfered with Daugherty’s and Hunter’s ability to perform adequate and timely examinations of work areas for safety hazards.

The area guard with the door at the No. 3 belt drive was not identified, recorded, and corrected, indicating that several preshift and onshift examinations were not adequately performed. Additionally, another preshift examination was required to be conducted in the area between 10:00 a.m. and 1:00 p.m. because miners were working a 9 hour shift that day, and Hatfield was assigned to work on the belt conveyors. This preshift examination was not conducted. Moreover, an adequate onshift examination was not conducted of the No. 3 belt. Daugherty began the onshift examination but only examined one crosscut on each end of the No. 3 belt. He did not examine 960 feet of the belt. Daugherty improperly documented in the onshift examination record book that all of the belts were examined in their entirety and that no hazards were present. Several

noncontributory citations and orders were issued for hazards observed along the three belt conveyors at this mine:

1. A 104(d)(1) Order No. 8295645 was issued because of a violation of 30 CFR § 75.400 along the No. 3 belt conveyor. Accumulations of loose coal, coal fines, and float coal dust were present at various places along the No. 3 belt including the belt drive, where the fatal accident occurred, and the tailpiece. The accumulations at the belt drive were 58 inches wide, 35 feet long, and up to 11 inches deep. The accumulations at the tailpiece were 36 inches wide, 55 inches long, and 6 inches deep. The belt was rubbing a stuck roller as well as accumulations at the tailpiece and accumulations at the belt drive. There were also two stuck top rollers and a bottom roller turning against the mine floor and float coal dust. One tandem roller was rubbing combustible material between the speed reducer and the tandem roller.
2. A 104(d)(1) Order No. 8295644 was issued for a violation of 30 CFR § 75.400 along the No. 2 belt conveyor because seven bottom belt rollers were turning in coal fines that were 30 inches wide, 48 inches long, and up to 12 inches deep.
3. A 104(a) Citation No. 8295653 was issued for a violation of 30 CFR § 75.1731(a) because the No. 1 belt conveyor rubbed a flat surface on a stuck bottom roller where combustible material had accumulated.
4. A 104(a) Citation No. 8295646 was issued for a violation of 30 CFR § 75.1731(b) along the No. 3 belt conveyor because the belt was not aligned and was rubbing a chain near combustible material.
5. A 104(a) Citation No. 8295648 was issued for a violation of 30 CFR § 75.1731(a) because 4 of the damaged rollers on the moving No. 3 belt were creating ignition sources.
6. A 104(a) Citation No. 8295654 was issued for a violation of 30 CFR § 75.1722(a) because the No. 2 belt was not adequately guarded, allowing miners to contact moving pulleys and rollers. The speed reducer pulley had worn holes in the metal guard, the guard was not fastened and could easily be moved to allow access to the moving drive rollers, and the hold-down roller was not guarded.
7. A 104(a) Citation No. 8295655 was issued for a violation of 30 CFR § 75.1722(a) because the No. 1 belt drive was not adequately guarded. The chain link fence was held in place in some locations with twisted wire and could be easily moved to allow access to the moving belt drive. Also the ends the belt tandem, which were 12 inches from the fence, were not guarded.

All of these citations and orders were issued for violations of mandatory standards that are required to be identified by examiners. These conditions were obvious and extensive and should have been identified, recorded, and corrected.

Experience and Training

Hatfield had 23 years of total mining experience and had been employed at this mine since August 12, 2016. He had received task training at this mine as a beltman, scoop operator, feeder attendant, and shot firer. His last annual refresher training was conducted on October 27, 2016. No training deficiencies were identified during the investigation.

ROOT CAUSE ANALYSIS

MSHA conducted an analysis to identify the basic cause of the accident correctable through reasonable management controls that, if eliminated, would have either prevented the accident or mitigated its consequences.

Listed below are root causes identified in the investigation and the operator's implemented corrective actions that could prevent a recurrence of this type of accident.

1. Root Cause: The mine operator did not have effective programs, policies, or procedures to ensure that belt drives at the mine were adequately guarded. The inadequate area guard with a "door" at the No. 3 belt drive created a hazardous condition that allowed a hazardous practice for miners working on, and/or being in close proximity to, the moving belt drive without first de-energizing it and blocking it against motion.

Corrective Action: All belt drive guards were redesigned to remove the "door" and/or area guarding and are now adequate. The mine operator has implemented written procedures that will ensure that belt drives are de-energized and blocked against motion prior to removing guards and performing work. All employees have been trained in these procedures and a lock and tag have been provided at belt power centers. The mine operator has trained all employees in hazard recognition and avoidance while working around moving conveyor belts and their associated components.

2. Root Cause: The mine operator failed to ensure that persons conducting examinations at this mine have been adequately trained to perform thorough examinations that will identify hazards. Citations and orders have been issued during this investigation because examiners did not identify violations of mandatory standards.

Corrective Action: Certified foremen have attended a training course on their roles and responsibilities as foremen and how to recognize hazards.

CONCLUSION

The victim received fatal injuries when he came in contact with the rotating shaft of a belt drive tandem roller. This occurred because the belt drive was not adequately guarded and the mine operator did not have effective programs, policies, or procedures in place to ensure that prior to performing work in close clearance areas around conveyor belt drives, power was de-energized, and machinery was blocked against motion.

Approved:

Scott M. Beverly
Acting District Manager

Date

ENFORCEMENT ACTIONS

1. Section 103(k) Order No. 8306750 was issued to R & C Coal, LLC, #2 Mine

A fatal accident occurred at this operation on January 26, 2017, a miner was working around the No. 3 Conveyor Belt Drive. This order is issued to assure the safety of all persons at this operation. It prohibits all activity at the mine until MSHA has determined that it is safe to resume normal mining operations. The mine operator shall obtain prior approval from an authorized representative for all actions to recover and/or restore operations to the affected area.

2. Section 104(a) Citation No. 8302547 was issued for a violation of 30 CFR § 75.1725(c) to R & C Coal, LLC, #2 Mine

The operator failed to ensure that the power was off and that machinery was blocked against motion prior to performing maintenance work on the No. 3 belt drive. A miner was performing routine cleanup work around the No. 3 belt drive while it was running when he came in contact with bolts that were protruding from the outby tandem roller shaft, resulting in fatal injuries.

3. Section 104(a) Citation No. 8302548 was issued for a violation of 30 CFR § 75.1728(c) to R & C Coal, LLC, #2 Mine

A miner received fatal injuries while attempting to remove coal spillage from beneath the No. 3 belt conveyor drive while it was in motion. Coal spilled beneath conveyor drives shall not be removed while the conveyor is in motion except where it can be done without endangering persons. This could be accomplished by adequate guarding and the use of a shovel with a long straight handle. In order to terminate this citation the operator shall install adequate guarding and provide a shovel with a long straight handle. The operator shall also train all employees on hazard recognition and avoidance while shoveling near moving conveyor belts and their associated components.

4. Section 104(a) Citation No. 8295656 was issued for a violation of 30 CFR § 75.1722(a) to R & C Coal, LLC, #2 Mine

Guarding provided at the No. 3 belt drive is not adequate to prevent persons from coming in contact with moving machine parts which may cause injury. The area around the belt drive is primarily guarded by chain link fencing that is not securely fastened. It is attached to posts with clamps and the posts are wedged against the mine roof with screw jacks which can easily become dislodged. Another piece of expanded metal guarding that measures 25 inches by 48 inches is provided in an area near the boom of the belt drive. This guard is not firmly bolted to the fencing and

can be easily installed and removed by simply hanging it onto the chain link fence. This guard was referred to as a "door" when interviewing miners and was frequently being removed to gain access into a restricted area to perform clean up duties around the belt drive. This guarding was installed in such manner that it could be easily defeated. This condition also resulted in a violation of 30 CFR 75.1722(c) because the "door" was not securely in place and could be easily removed.

5. Section 104(d)(2) Order No.8302549 was issued for a violation of 30 CFR § 75.360(a)(1) to R & C Coal, LLC, No. 2 Mine

The operator failed to conduct a preshift examination in all areas of the mine that were required to be examined within 3 hours preceding a fixed 8 hour interval on January 26, 2017. This mine worked a 9 hour shift from 5:00 am to 2:00 pm. The preshift examination that was conducted prior to the beginning of the shift on this date expired at 1:00 pm. This would have required an additional examination to have been conducted between 10:00 am and 1:00 pm. A fatal accident occurred at the No. 3 belt drive sometime between the hours of 11:00 am and 2:00 pm. In addition to not performing this required examination, other examinations that had previously been conducted were not adequate. During an inspection of the mine, the following violations and orders were issued for violations of mandatory standards that preshift examiners are required to identify:

- 104(d)(1) Order No. 8295644 for a violation of 75.400 along the No. 2 belt conveyor,
- 104(d)(1) Order No. 8295645 for a violation of 75.400 along the No. 3 belt conveyor,
- 104(d)(1) Order No. 8295646 for a violation of 75.400 along the No. 1 belt conveyor,
- 104(a) Citation No. 8295653 for a violation of 75.1731(a) on the No. 1 belt conveyor,
- 104(a) Citation No. 8295648 for a violation of 75.1731(a) along the No. 3 belt conveyor,
- 104(a) Citation No. 8295654 for a violation of 75.1722(a) at the No. 2 belt drive, and
- 104(a) Citation No. 8295655 for a violation of 75.1722(a) at the No. 1 belt drive.

These conditions were obvious and extensive and existed for several shifts. The practice of not recognizing and correcting hazardous conditions exposes miners to injury by allowing them to work in areas where hazardous conditions exist. This violation is an unwarrantable failure to comply with a mandatory standard.

6. Section 104(d)(2) Order No.8295647 was issued for a violation of 30 CFR § 75.362(b) to R & C Coal, LLC, No. 2 Mine

The operator failed to conduct an adequate onshift examination of the No. 1, No. 2, and No. 3 conveyor belts at this mine. All three belt conveyors at this mine were found to have obvious and extensive hazards, such as accumulations of combustible materials, stuck belt rollers, and inadequate guarding at belt drives. Violations of

these standards are required to be identified by onshift examiners. The following violations and orders were issued during an inspection of the mine following a fatal accident:

- 104(d)(1) Order No. 8295644 for a violation of 75.400 along the No. 2 belt conveyor,
- 104(d)(1) Order No. 8295645 for a violation of 75.400 along the No. 3 belt conveyor,
- 104(d)(1) Order No. 8295646 for a violation of 75.400 along the No. 1 belt conveyor,
- 104(a) Citation No. 8295653 for a violation of 75.1731(a) on the No. 1 belt conveyor,
- 104(a) Citation No. 8295648 for a violation of 75.1731(a) along the No. 3 belt conveyor,
- 104(a) Citation No. 8295654 for a violation of 75.1722(a) at the No. 2 belt drive, and
- 104(a) Citation No. 8295655 for a violation of 75.1722(a) at the No. 1 belt drive.

In addition to not recognizing and recording these hazards, the examiner also failed to examine the No. 3 belt in its entirety. In an interview, the examiner stated he had traveled one crosscut on each end of the No. 3 belt which left 960 feet of this belt that wasn't examined. The record book indicates that all belts were examined in their entirety and that no deficiencies were discovered. The practice of not recognizing and correcting hazardous conditions exposes miners to injury by allowing them to work in areas where hazardous conditions exist. The operator engaged in aggravated conduct constituting more than ordinary negligence by not recognizing and correcting these hazards and by recording that all the belts were "ok" even when the examiner hadn't completed exams in their entirety. This violation is an unwarrantable failure to comply with a mandatory standard.

Appendix A
Persons Participating in the Investigation
(Persons interviewed are indicated by a * next to their name)

R & C Coal, LLC

*Mark Daugherty	Owner/Superintendent
*Raymond Hunter	Section Foreman
*Tracy Hall	Beltman
*Darrell Ousley	Cutting Machine Operator
*Bryan Allen	Scoop Operator
*Billy Hall	Coal Drill Operator
*Joey Taylor	Outside Electrician
*Stanley Osborne	Outside Man

Kentucky Division of Mine Safety

Tim Fugate	Chief Investigator
Rick Johnson	Acting Director
Randal Smith	Branch Manager
Danny Hurt	Chief Electrical Inspector
John Ferrari	Mine Safety Specialist II
Robert Matthews	Mine Safety Specialist I

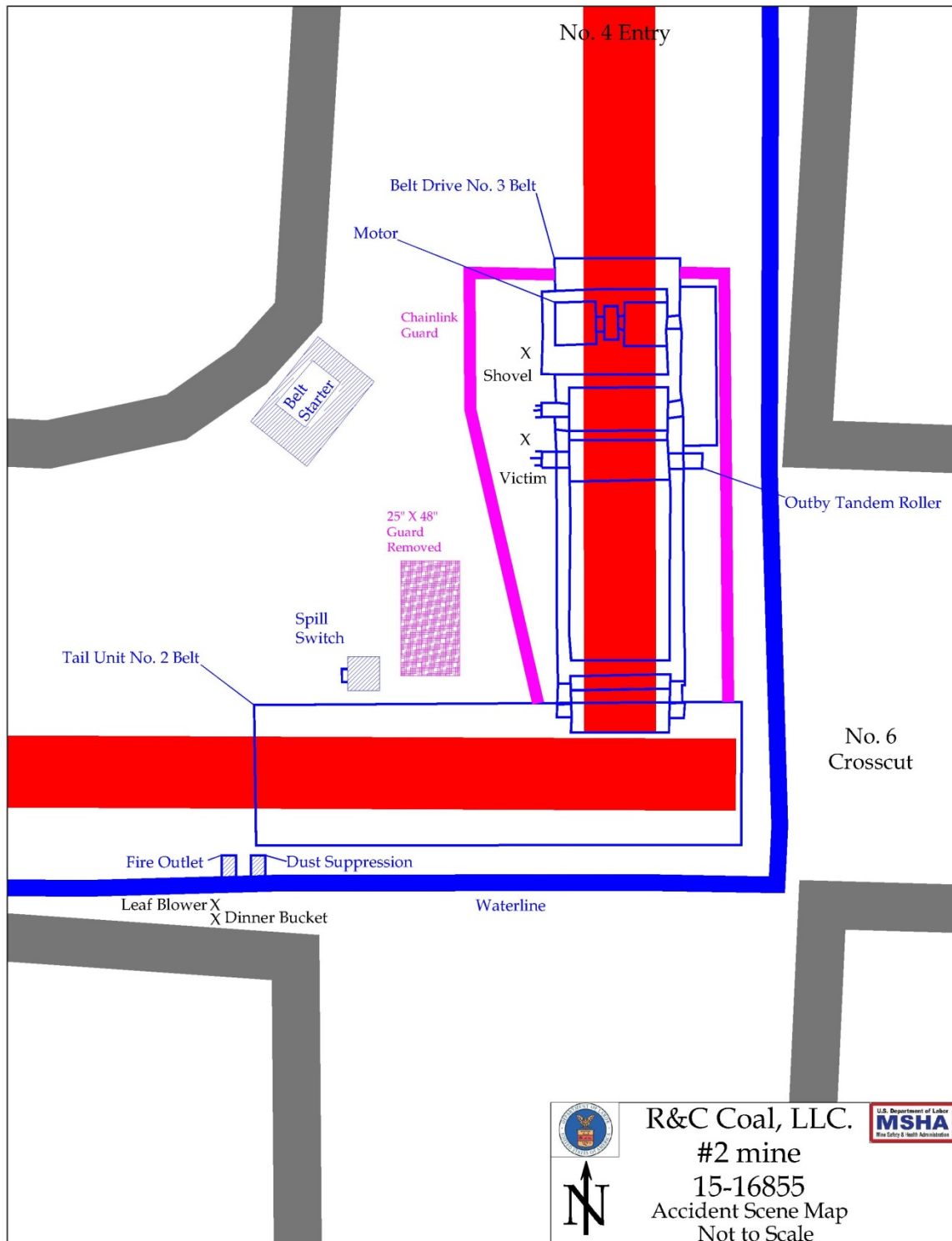
Mine Safety and Health Administration

Clayton E. Sparks	District Manager
Benjamin Harding	Assistant District Manager - Technical
Lloyd Robinette	Assistant District Manager - Enforcement
Terry Sheffield	Staff Assistant
Danny Deel	Supervisory Mine Safety and Health Inspector
Robert Clay	Family Liaison
Robert Bates	MSHA Technical Support
Anthony Benton	Mine Safety and Health Inspector
Billy Stiltner	Mine Safety and Health Inspector
Rodney McIntosh	Mine Safety and Health Inspector
Jordan Rose	Electrical Engineer
Quentin Blair	Mine Safety and Health Specialist (Electrical)

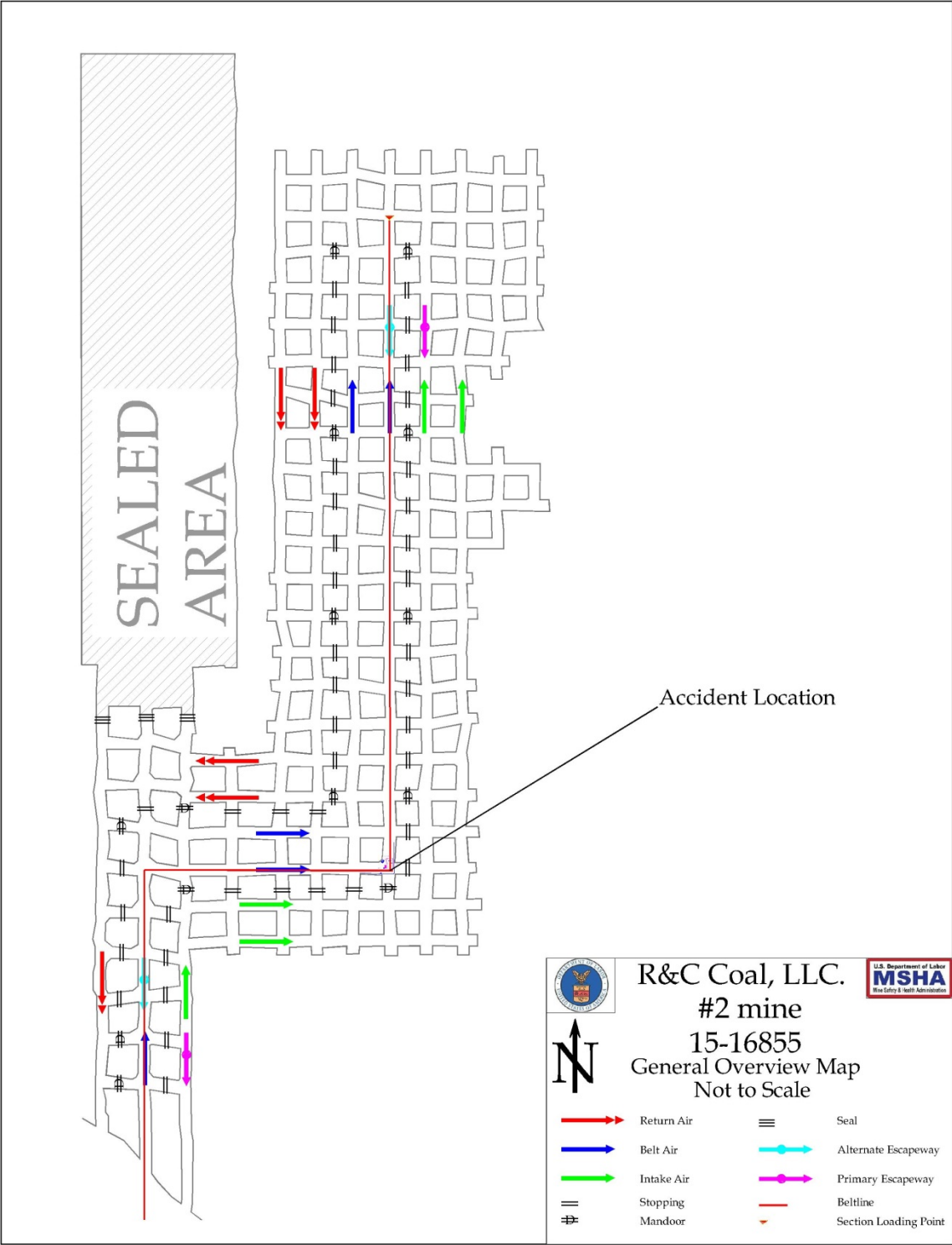
Appendix B Guard Installation



Appendix C Location of the Accident



Appendix D
Mine Map



Appendix E Victim Information

Accident Investigation Data - Victim Information

U.S. Department of Labor
Mine Safety and Health Administration



Event Number: **6 3 9 7 6 2 0**

Victim Information: **1**

1. Name of Injured/Ill Employee: <i>Ray Hatfield Jr.</i>		2. Sex: <i>M</i>	3. Victim's Age: <i>42</i>	4. Degree of Injury: <i>01 Fatal</i>	
5. Date(MM/DD/YY) and Time(24 Hr.) Of Death: <i>a. Date: 01/26/2017 b. Time: 11:15</i>				6. Date and Time Started: <i>a. Date: 01/26/2017 b. Time: 7:00</i>	
7. Regular Job Title: <i>001 Beltman</i>		8. Work Activity when Injured: <i>011 Belt Cleaning</i>		9. Was this work activity part of regular job? <div style="text-align: right;">Yes <input type="checkbox"/> X No <input type="checkbox"/></div>	
10. Experience a. This	Years	Weeks	Days	b. Regular Job Title:	Years Weeks Days
Work Activity:	<i>0</i>	<i>23</i>	<i>6</i>	Job Title:	<i>0 23 6</i>
c. This Mine:	Years	Weeks	Days	d. Total Mining:	Years Weeks Days
	<i>0</i>	<i>23</i>	<i>6</i>		<i>23 0 0</i>
11. What Directly Inflicted Injury or Illness? <i>035 Belt Drive</i>			12. Nature of Injury or Illness: <i>370 Multiple Injuries</i>		
13. Training Deficiencies: Hazard: <i>New/Newly-Employed Experienced Miner:</i> Annual: Task:					
14. Company of Employment: (if different from production operator) <i>Operator</i> Independent Contractor ID: (if applicable)					
15. On-site Emergency Medical Treatment: Not Applicable: First-Aid: CPR: EMT: Medical Professional: None: X					
16. Part 50 Document Control Number: (form 7000-1)			17. Union Affiliation of Victim: <i>9999 None (No Union Affiliation)</i>		